Making the link

Case management and concurrent disorders

AADAC
Alberta Alcohol and Drug Abuse Commission
An Agency of the Government of Alberta

Table of contents

Introduction 3
Building capacity—A framework for serving Albertans affected by addiction and mental health issues 4
Case management 4
- Definition 4
- Case management models 5

Principles of case management 7
Considerations and challenges 11
Treatment planning 13
- Initial treatment decisions 14
- Designing an initial treatment plan 14

Treatment themes 15
Appendices
- A: Building capacity—A framework for serving Albertans affected by addiction and mental health issues 17
- B: Models of case management 19
- C: Domains of care 22
- D: Concurrent disorder capable service 23
- E: Potential challenges 24
- F: Working together 25
- G: Sample scope of practice guidelines 28

Introduction

In 2004, the *Provincial Mental Health Plan for Alberta*[1] identified as a strategic direction increasing service delivery system capacity to respond to the needs of people who have concurrent disorders.[2] In the plan, the Alberta Alcohol and Drug Abuse Commission (AADAC) was asked to take the lead in working collaboratively with health regions and key stakeholders to develop a provincial framework for service. The result of these efforts was published in *Building capacity—A framework for serving Albertans affected by addiction and mental health issues.*[3] The framework outlines a seamless system of care that emphasizes collaboration amongst service providers. This approach is one in which addiction and mental health service providers have a shared responsibility for flexible and cohesive service to clients who have concurrent disorders. In this model, each program and each clinician is expected to develop a fundamental level of "concurrent disorder capability"[4] for providing service.

The framework is intended to guide a variety of service organizations; Alberta has a range of services for people who have concurrent disorders. Examples of service sites are physicians' offices, hospital emergency rooms and psychiatric inpatient units, mental health clinics, AADAC outpatient and residential treatment centres (adult and youth) and AADAC Funded Services. Service may focus on specific populations and/or (depending on the nature of the concurrent disorder) offer different levels or types of care on a service continuum. These points of care are sometimes referred to as domains of care.[5]

While local and regional case management practices will reflect this diversity of service, they will also share a common philosophical approach and foundation that is based on the provincial framework. Service providers in Alberta have been supplying case management as part of their services for a long time. Successful linkages already exist, and in these instances, formalization of the case management practices would be the goal.

The purpose of this document is to provide an overview and understanding of case management that will support a co-ordinated and consistent approach to helping people who have concurrent disorders whatever "door" is the starting point for service. It is intended to be a point of reference to help service providers develop local and/or regional case management practices and/or formalize existing practice.

[1] Provincial Mental Health Planning Project. (2004). *Advancing the mental health agenda: A provincial mental health plan for Alberta*. Edmonton, AB: Author.

[2] In this document the term *concurrent disorders* is used the describe to co-occurrence of an addiction issue and a mental health problem. For AADAC purposes, the term "concurrent disorders" identifies the client population that presents with a substance abuse and/or gambling problem in addition to a psychotic, affective, behavioural or severe personality disorder.

[3] AADAC. (2005). *Building capacity—A framework for serving Albertans affected by addiction and mental health issues*. Edmonton: Author. (p.31). This document can be downloaded from www.aadac.com

[4] See Appendix D for a description of concurrent disorder capable service.

[5] Domains of care are briefly described in Appendix C of this document. For a detailed explanation, see *Building capacity—A framework for serving Albertans affected by addiction and mental health issues*, available from www.aadac.com

Building capacity—A framework for serving Albertans affected by addiction and mental health issues

The philosophical base of the provincial framework for serving Albertans affected by addiction and mental health issues is collaboration amongst partners to provide a seamless system of care. Case management principles are grounded in the provincial framework, with attention to principles and characteristics of service and are also derived from current research and case management practices.

For a summary of the principles of service and characteristics of service from the provincial framework see Appendix A.

Case management

Definition

Case management can be broadly defined as the activities that happen to help people navigate their environment. Case management has been defined in different ways, depending on the context of the case management work. It is important to have agreement on what case management means to the service providers involved.

Substance Abuse and Mental Health Services Administration (SAMHSA) cites the following definitions:[6]

- planning or co-ordinating a package of health and social services to meet a particular client's needs
- ensuring that consumers are provided with whatever services they need in a co-ordinated, effective and efficient manner
- helping people who need assistance from several helpers at once
- monitoring, tracking and providing support throughout the course of a person's treatment and after
- assisting the person to re-establish an awareness of internal resources such as intelligence, competence, and problem-solving abilities; establishing and negotiating lines of operation and communication between the person and external resources; and advocating[7] with those external resources in order to enhance the continuity, accessibility, accountability, and efficiency of those resources

[6] Substance Abuse and Mental Health Services Administration. (2000). *Case management for substance abuse treatment: A guide for treatment providers.* Rockville, MD: Author. (p.2).

[7] Traditionally, advocacy is a case management activity that is most often directed at other service providers. In Alberta, a collaborative and co-operative approach to service is emphasized.

- assessing the needs of the client and client's family, when appropriate, and arranging, co-ordinating, monitoring, evaluating and advocating for a package of multiple services to meet the person's complex needs

According to Mehr,[8] the following activities can be categorized as six core functions of case management.

- Assessment: gathering information about the person's circumstances, problems, needs and goals
- Planning: identifying activities that will further the achievement of the client's goals, promote problem solving, meet needs; identify who will do what
- Implementation: may involve linking to services, providing services and recommending services on behalf of the client
- Monitoring: ongoing regular contact with the client
- Evaluation: assessing the effectiveness of the plan and activities based on achieving the goals
- Involvement: staying involved with the client in a helping relationship while acknowledging the parameters of that relationship and the client's wishes and needs and agency mandate

Case management models

Case management has been described as the core service delivery intervention for clients with addiction and mental health issues.[9]

Models of case management have developed over the last thirty years. Originally, case management referred to the activities of arranging services for a client, acting as a broker and an advocate and helping the client negotiate a system of care. Over time, this approach was modified to create models that differed in intensity, underlying theory or focus, and clinical involvement.[10] Descriptions of the main models can be found in Appendix B.

Since the 1980s the dominant model employed for persons with severe mental illness has been the clinical case management model.[11] [12] Researchers have identified clinically-focused case management as one of four main components of service for clients who have concurrent disorders. The other three components are screening and assessment for concurrent disorders, individual counselling for substance abuse, and group counselling for

[8] Mehr, Jim. (2001). Case management: A review with implications for services for concurrent severe mental illness and alcoholism or substance abuse. *Psychiatric Rehabilitation Skills. 5*(1) 80-107.

[9] Mueser, K., Noordsy, D., Drake, R., & Fox, L. (2003). *Integrated treatment for dual disorders: A guide to effective practice*. New York: Guilford Press.

[10] Mehr, Jim. (2001). Case management: A review with implications for services for concurrent severe mental illness and alcoholism or substance abuse. *Psychiatric Rehabilitation Skills. 5*(1) 80-107.

[11] Mueser, K., Noordsy, D., Drake, R., & Fox, L. (2003). *Integrated treatment for dual disorders: A guide to effective practice*. New York: Guilford Press. p. 106.

[12] This definition of clinical case management includes but is not limited to providing clinical services, facilitating other services, potentially working in teams to provide service and offering outreach services.

substance abuse. These components are described from a mental health perspective and are offered as an adjunct to a sound base of existing mental health services.[13]

Clinical case management is identified in *Building Capacity* as part of a range of services for people who have concurrent disorders.[14]

The case manager working from a clinical case management model co-ordinates treatment and provides clinical services. Two strengths of this approach are that it is not feasible to separate these two activities over a longer period of time, and that the case manager must be client focused, as opposed to focusing solely on their environment (as in the brokerage model of case management).[15] As well, researchers note that "because more clinical services are provided directly, the chances of clients not receiving critical services because of poor follow-through on referrals can be minimized—an especially important concern…"[16]

Clinical case management fits with an ecological perspective in which the client and their environment are not viewed as separate from one another. Rather, the client and their environment exist in ongoing transaction with each other, and interventions are directed at both.[17]

The clinical case management model includes the co-ordination of services and advocacy functions described in the brokerage model of case management. The overall goals of clinical case management are[18]

- assess client needs (AADAC assesses for addiction issues; mental health service providers assess for mental health issues)
- identify and provide services to meet those needs
- monitor outcomes to determine the success of treatment/need for other services

Researchers note "clinical case management is most effective when it is provided in the context of a multidisciplinary treatment team."[19] The clinical case management model has evolved to incorporate aspects of the Assertive Community Treatment (ACT) model and the Strengths Model. (Both of these models are described in Appendix B.)

[13] Mehr, J. (2001) Case management: A review with implications for services for concurrent severe mental illness and alcoholism and substance abuse. *Psychiatric Rehabilitation Skills*, 5(1) 102.

[14] AADAC. (2005). *Building capacity—A framework for serving Albertans affected by addiction and mental health issues*. Edmonton: Author. p.31.

[15] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administrations (SAMHSA). *Comprehensive case management for substance abuse treatment: Treatment Improvement Protocol (TIP) Series 27*. Retrieved August 25, 2003 from http://www.health.org/_usercontrols/printpage.aspx

[16] Mueser, K. Noordsy, D., Drake, R. & Fox, L. (2003). *Integrated treatment for dual disorders: A guide to effective practice*. New York: Guilford Press.

[17] In an ecological model the client and their environment are referred to as the "ecosystem" and the ecosystem is the target for case management efforts.

[18] Mueser, K., Noordsy, D., Drake, R. & Fox, L. (2003). *Integrated treatment for dual disorders: A guide to effective practice*. New York: Guilford Press.

[19] Mueser, K. Noordsy, D., Drake, R. & Fox, L. (2003). *Integrated treatment for dual disorders: A guide to effective practice*. New York: Guilford Press. p. 88.

The ACT model has influenced clinical case management so that "outreach is a common component of clinical case management, as are shared caseloads on multidisciplinary teams."[20]

Principles of case management[21]

1. Case management is grounded in a client-led, empowerment-based philosophy

Clients make decisions about their care when possible; they are, in effect, co-case managers. Empowerment strategies include helping clients discover their strengths and learning about their rights. Harm reduction approaches, where warranted, are legitimate treatment approaches.

Practice example: A client and counsellor[22] may discuss strategies to reduce alcohol use. Service is provided without prejudice to the person's decision about abstinence.

2. There is a designated, primary case manager

Building Capacity notes: "the role of the primary case manager is a key factor for the success of the framework."[23] The primary case manager is clearly designated, and has the major role and responsibility for co-ordinating case management activities. The person who becomes the primary case manager is determined by assessing several variables. With the exception of the most severe cases, the person's wishes in this are paramount.

Considering the severity of each concurrent disorder is a way to help identify the primary case manager and corresponding domain of care.[24] (See Appendix C for further explanation of the domains of care.) Other variables are prior and existing relationships with the professionals involved and the quality of those relationships, and level of involvement of the family. The primary case manager is decided on a case-by-case basis, and may change over time. It is important that

- the client knows who the primary case manager is
- all service providers know who the primary case manager is
- the responsibilities of the primary case manager role are defined and communicated

[20] Mueser, K., Noordsy, D., Drake, R. & Fox, L. (2003). *Integrated treatment for dual disorders: A guide to effective practice*. New York: Guilford Press. (p. 89).

[21] Parts of these principles are adapted from: Substance Abuse and Mental Health Services Administration. (2000). *Case management for substance abuse treatment: A guide for treatment providers*. Rockville, MD: Author.

[22] The term *counsellor* is used throughout this document. In this case it refers to the activity of counselling as opposed to a job description or professional designation. Health professionals that counsel may be nurses, psychologists, social workers or others.

[23] AADAC. (2005). *Building capacity—A framework for serving Albertans affected by addiction and mental health issues*. Edmonton: Author. (p.31).

[24] AADAC. (2005). *Building capacity—A framework for serving Albertans affected by addiction and mental health issues*. Edmonton: Author.

There may also be an initial case manager[25]: the person whom the client sees first, especially when the client does not already have involvement with another service provider. The initial case manager may or may not become the primary case manager.

Practice example: A client comes to AADAC for help with a problem with cocaine. He has a diagnosis of bipolar disorder and has an established relationship with his community mental health worker. This person binges on cocaine about once a month. The AADAC counsellor, with the client's permission, will communicate with the mental health worker according to their site guidelines and confirm who is the primary case manager. In this example, the mental health worker is most likely the logical primary case manager.

3. Case management ensures continuity of care

Service providers develop protocols to create a seamless system of care. This includes referral protocols to check on follow through and exchanges of information (attending to confidentiality policies) that are regular and timely. There is agreement between service providers about how and when exchanges of information need to happen, and a protocol that clearly outlines this is communicated and distributed to all service providers. Involvement with people who have concurrent disorders is likely to be longer-term; continuing care arrangements from each service are a basic component of care. In the example provided below, a client is discharged early from a residential addictions treatment centre. Continuity of care is attended to through co-ordination of services.

Practice example: A client has been admitted to an Early Admissions Program[26] at a residential addiction treatment centre. Mental health diagnoses include bipolar disorder and borderline personality disorder, as well as an eating disorder. Assessment for addiction concerns reveals significant stimulant abuse. Over time, the person begins to speak about thoughts of self-harm. Further assessment determines that stabilization is necessary, and that concurrent disorder enhanced services are more appropriate for her needs. The following actions are taken:

- The client's community mental health worker is contacted for recommendations and sent a copy of the client's progress review.
- The client or counsellor calls the psychiatrist at the eating disorders program and an appointment is booked.
- Her mother is contacted to help arrange transportation home.

[25] The intake worker will often be the person to work in the role of initial case manager.

[26] An Early Admissions Program for addictions treatment, also known as a Continuous Admissions Program, is a program that allows a person to be admitted to a treatment centre prior to the formal treatment program. If, on their application, clients indicate significant health, mental health or behavioural concerns, then they may be booked for an early admission bed. This allows for more time with nurses and counsellors for assessment, including treatment planning, and an opportunity to settle in more gradually.

- The case management responsibility is transferred or confirmed. In this case, the community mental health worker is the most likely to assume the role of primary case manager.
- The file may be flagged for a follow-up call to ensure continuity of care and to offer further addictions treatment support and information when appropriate.

4. Service is individualized and culturally sensitive approaches are used

People who have concurrent disorders are not a uniform group. Case management for specific groups like youth, women, seniors or Aboriginal people is not going to be the same. Flexibility to tailor service to group and individual needs is necessary, including varying the intensity of the case management efforts.

Practice example: A concurrent disorder group for seniors will have an appropriate pace and content for older adults. The group will be relevant to their age group. Content will address developmental challenges for their life stage, such as coming to terms with their lives as they have lived them.

5. Existing client strengths and resources are considered

Case management includes an assessment of need for resources that considers client strengths and current involvement with existing formal or informal resources. Family members are involved, when it is in the best interests of the client, and are a potential source of support for the client. Where appropriate, service providers work to engage, educate and support family members.

Practice example: A father who is self-employed has the flexibility to drive his 15-year-old son, who has a diagnosis of depression and uses marijuana, to appointments. When his son is not able to track his appointment times or arrange transportation, the father helps co-ordinate care by keeping track of the appointment times and providing transportation.

6. There is a holistic approach to case management activities

Case management activities have a wide range; activities look at different areas of a person's life. Services are flexible to meet client need while attending to service mandate.

Practice example: A case manager may advocate for housing, refer to a credit counselling agency, or arrange a case conference for a client.

7. Service that is least intrusive but also ensures safety and effectiveness is considered first

Safety and stabilization are the first priorities.

Practice example: At intake a person is screened for admission to a drop-in outpatient addictions group. The person is suicidal and therefore,

not appropriate to participate in the group. The counsellor phones the mental health crisis team to access support.

8. Case management involves advocacy actions

Clients are taught advocacy and other case management skills when appropriate and clients receive assistance with those things that they cannot do. In keeping with working from an empowerment philosophy, counsellors can teach self-advocacy skills by providing information about service systems and helping clients develop skills to navigate service systems. This is done based on a counsellor's clinical assessment of the extent of a person's need for assistance and the client's ability to begin to advocate for themselves.

Practice example: In the treatment phase, an addiction counsellor advocates for a young person to continue to attend school at an outreach site. Once the counsellor assesses that the person is far enough along in his or her recovery efforts, the focus shifts from advocating for the client to the addiction counsellor teaching self-advocacy skills.

9. Case management is practical

Pressing life circumstances have priority and practical help is offered.

Practice example: A person is provided with information on obtaining legal advice for an imminent court case before effort is directed at attending residential treatment. Dealing with the court case first helps the client where help is needed, and enables the client to focus on treatment when he or she does attend treatment.

10. Efforts are community based and focused

People who come into either an addiction service or a mental health service are provided with or connected to the services that they need, with a first preference to appropriate services that are available in their community. Where possible, clients are referred to local support groups that address mental health and/or addictions issues.

Practice example: A client is referred to Gamblers Anonymous. The service provider helps the person to have a positive experience at the self-help group by providing information about the structure of the meeting, the underlying philosophy of the twelve-step programs, and potential hurdles for someone who is on psychotherapeutic medication.

11. Case management is anticipatory

The case manager uses their experience and knowledge to anticipate problems and challenges and suggests options to manage them.

Practice example: A person leaves a residential addictions treatment centre insisting that he is "cured." He says that his depression was only due to the alcohol use. However, assessment has revealed factors such

as a familial history of depression and that the depression pre-dated the alcohol abuse. The addictions counsellor provides education about relapse prevention and how the depression may connect to that or affect efforts at sobriety. The addictions counsellor helps the client to develop a continuing care plan and strongly encourages outpatient addiction counselling and continued contact with his mental health therapist and psychiatrist. With permission, the addictions counsellor may contact the mental health service provider to discuss concerns.

12. Case management considers agency functions and scope of practice of clinicians

Roles and responsibilities of professionals involved in the treatment plan are necessarily informed by the mandate of the agency and each clinician's scope of practice. The majority of services in Alberta will seek to provide a Concurrent Disorder Capable level of care. See Appendix C for a definition and discussion of domains of care and Appendix D for a description of Concurrent Disorder Capable level of care. See Appendix G for an example of scope of practice guidelines.

Practice example: An addiction counsellor encourages medication compliance by checking in with the person to make sure that they are remembering to take their medication. An addiction counsellor may contract with a client, and obtain written permission to contact their mental health worker, if they are not taking their medication. A psychiatrist or family physician adjusts medication based on client need.

Considerations and challenges

Complexity

Concurrent disorders are not a single condition. They include an array of addiction and mental health problems. These problems vary in their cause, symptoms, and the effect they have on people's lives. Every person's situation is different, including their strengths and resources and their level of motivation to change. Accordingly, service needs vary considerably.[27]

Historical systemic challenges

System challenges have included differences in treatment philosophies, service delivery, staffing and other resources, lack of knowledge of the other service system's expertise, and the lack of shared screening tools. For a list of potential areas of difference between service providers see Appendix E. In Alberta, solutions to some of these challenges have already been put in place.

[27] AADAC (2005). *Building capacity—A framework for serving Albertans affected by addiction and mental health issues*. Edmonton, AB: Author.

Service providers who are aware of potential areas of difference can strategize to avoid pitfalls. See Appendix F for ideas on how to build solid service linkages and resolve challenges to collaborative service.

Stigma

Clients may be reluctant to disclose at either service that they have concurrent disorders, due to the stigma attached to having both addiction and mental health issues. Service providers can counter this by telling people who have concurrent disorders that they are welcome at the site, and that concurrent disorders are treatable and progress in recovery is attainable. They can also display information that clearly welcomes those who have concurrent disorders. Ongoing screening for either an addiction or a mental health issue, and referral when appropriate, counters stigma by making the issue known.

Resources

Case managers can be challenged by wait times for services that are oversubscribed. From an individual practitioner's perspective, case management activities are difficult to fit into an already solidly booked schedule; effective case management is time consuming. One of the principles of service in the provincial framework is that case management practices are sustainable. The case management protocol is realistic and resources are in place so that service providers can apply the protocol. Ensuring that a case management protocol is workable requires substantial and comprehensive input from direct service practitioners. While direct service practitioners provide feedback and advice, a role of leadership is to advocate for the development and implementation of services, to monitor services,[28] and specifically, to commit needed financial resources to improve service.

Undiagnosed mental health issues

Case management may begin long before there is any diagnosis. For example, a person may have an undiagnosed mental health issue, or they may simply have withdrawal symptoms that mimic symptoms of mental health disorders. (AADAC's role is to screen for mental health disorders. Screening and referral when warranted is considered to be an ongoing process.)

While the nature of treatment planning is that it is flexible and evolving, this changing symptom picture can make treatment planning with any certainty challenging.

[28] AADAC. (2005). *Building capacity—A framework for serving Albertans affected by addiction and mental health issues*. Edmonton: AADAC

Treatment planning

Treatment planning is one of the core functions of case management, and likely the most complex function. The purpose of treatment planning is to set goals and "identify the skills, knowledge, and action steps/interventions necessary to meet the goals."[29] The treatment plan is a roadmap: it points the way (the desired destination) and outlines the steps to get there. It provides the structure and the focus for the therapeutic contact, and helps the person focus energy on the specific steps that will help to resolve a larger issue.[30] It is also dynamic and integrates all relevant life areas.[31] Treatment planning is person-centered. Where clients are able to make their own decisions, they guide the treatment planning process.

Treatment planning begins with screening and assessment. A principle outlined in the provincial framework is that service includes universal screening for either addiction or mental health issues. Screening for either issue is part of a standard assessment process for addictions and health professionals. Some sites may choose to work out a joint intake and screening/assessment process.

AADAC fully supports screening for mental health issues and has implemented screening for mental health issues for all AADAC clients.

Health Canada[32] states that a positive screen for either substance use or mental health disorders should be followed by:

- assessment to establish diagnosis,
- assessment of the level of psychosocial functioning and other disorder-specific factors,
- development of a treatment and support plan that seeks to sort out the interaction between the mental health and substance use difficulties and works toward a positive outcome for both sets of problems as well as other related problems.[33]

[29] Adams, G., & Grieder, D. (2005). *Treatment planning for person-centred care: The road to mental health and addiction recovery.* Burlington, MA: Elsevier Academic Press. (p.xii).

[30] Perkinson, R., & Jongsma, A. (1998). *The chemical dependence treatment planner.* New York: John Wiley & Sons, Inc.

[31] AADAC. (2005) *Building capacity—A framework for serving Albertans affected by addiction and mental health issues.* Edmonton: AADAC.

[32] Health Canada. (2002). *Best practices: Concurrent mental health and substance use disorders.* Ottawa, ON: Author.

[33] Two resources that may provide helpful information on treatment planning and treatment approaches for people who have concurrent disorders are *Best Practices: Concurrent Mental Health and Substance Use Disorders* by Health Canada (2001) and *Substance Abuse Treatment for Persons with Co-Occurring Disorders: Treatment Improvement Protocol* (TIP 42) by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment (SAMHSA) (2005). All AADAC sites have received library copies of these and other concurrent disorder-related resources and have been offered access to formal training opportunities.

Initial treatment decisions

Initial treatment decisions arise out of the screening and assessment process. They depend on the most immediate need of the person, and the scope of service at the "door" the client enters. Some universal considerations are

- Safety: Is the person at risk to harm themselves or others? Are they at risk of being harmed?
- Other crisis?
- Stabilization needs?
- Service match? Do they need a different service and assistance accessing that service? For addiction services: do they need detoxification or shelter services? For mental health issues: If they need immediate support from mental health services, is there a mental health crisis service? Is the hospital emergency room the appropriate choice?

Developing a site decision tree (an outlined series of steps for making decisions) with the participating service providers for treatment planning that reflects the scope of service each site offers and accounts for other variables (for example, rural or urban setting) is helpful. Site policy and procedure regarding transporting clients, and confidentiality in emergency situations, need to be outlined and communicated to staff, and other service providers.

The responsibility of the professional who is the initial contact is clearly outlined as an adjunct protocol to the decision tree. If clients are screened/ assessed as not appropriate to continue in treatment, they are to be formally linked to a more appropriate service. To do this, the initial case manager will follow the site-defined protocol. For example, the initial case manager contacts the service that they are referring to, books the appointment or has the client book the appointment, and helps the client get the information that is needed to access the service. The initial case manager may also have to negotiate for the client to be able to access the service. The primary case management responsibility is formally transferred or designated. This does not mean that involvement necessarily ends, only that the primary case manager role is transferred.

Ensuring that this linking happens is central to case management practices, and is one of the most critical tasks of case management.

Designing an initial treatment plan

There are some mental health and addiction services where there is immediate access, such as walk-in intake or clinic. If clients are well enough for non-crisis services or service that is not immediate, they may still benefit from an initial treatment plan until their first appointment or program start date. Working with clients to create an initial treatment plan that includes establishing a routine, eating healthily, exercising and using existing

(with an emphasis on family if appropriate) supports is helpful. This plan should include relapse prevention strategies and identify what to do if things deteriorate. Examples of actions counsellors can take are providing clients with a help-line number or other crisis number and encouraging them to use it if needed, or referring them to see their family physician or mental health worker if possible.

Treatment themes

Clinical case management includes direct service provision. Clinicians working with people who have concurrent disorders have suggested ten treatment themes.[14] The following themes are adapted from this work.

Accepting the mental health issue

Accepting the existence of a mental health issue means changing expectations and acknowledging that this may create limitations and will complicate the recovery from addiction. It is helpful to encourage the person to focus on what they can do to manage the concurrent disorder.

Accepting the addiction or substance abuse as a health issue

Any use of substances can decrease the ability of clients' to manage their mental health issue, and can make the symptoms of the mental health issue worse. Clinicians have to constantly educate clients about the effect the use of substances is having on their efforts at achieving and/or maintaining health.

Identifying the average range of thoughts, feelings and behaviours

It is important for counsellors to educate clients about what thoughts, feelings, and behaviours are in the healthy range, that is, what people who are not ill think, feel and do. It is difficult for clients to tell the difference between what are "normal" thoughts, feelings, and behaviours, and what is a symptom of their illness.

Differentiating between medication and drug use

Medication is sometimes seen as just another drug. Counsellors can help clients by pointing out the difference. Medication is intended to help promote stability and wellness. Alcohol and other drugs hurt these efforts. Alcohol and other drugs may also interfere with the action of the medication.

Family or community responses

Family members or others may not understand the full impact of a concurrent disorder. For example, they may think someone is just

[14] Hendrickson, E. *Modifying group treatment for seriously mentally ill substance abusers.* [Electronic version]. Retrieved December 18, 2005 from http://www.toad.net/~arcturus/dd/hendl.htm

not motivated to do anything. Counsellors can help clients by educating family members about concurrent disorders and encouraging a more balanced view. Counsellors can shift the focus to competencies and strengths and to what is working well right now and can offer support to the family in understanding concurrent disorders and their effects on people's lives.

Dealing with mental health issues

Clients may express outrage, and they may feel helpless or overwhelmed about the effect a mental health issues has on their lives. Counsellors can help clients to learn to manage it. By learning the skills they need to manage the mental health issue, clients can step away from feeling victimized by it.

Relapsing into addiction and/or return of psychiatric symptoms

When clients experience a return of psychiatric symptoms or relapse into their addiction, feelings of guilt and a sense of failure may arise. When mental health symptoms emerge, clients sometimes feel scared or think that their efforts have been useless or that nothing has changed. The counsellor's goal is to create and maintain hope by framing the relapse as a learning opportunity. In the case of psychiatric symptoms, clients have less control over symptoms appearing; counsellors should help clients focus on reducing stressors and managing symptoms when they do appear. For example, someone with a mood or anxiety disorder may find a review of cognitive-behavioural strategies helpful.

Suicidal ideation

It is likely that this client group has had thoughts of suicide, or attempted suicide. Clinicians need to constantly monitor for ideation and to review the risk for suicide if necessary.

Appendix A

Building capacity—A framework for serving Albertans affected by addiction and mental health issues

The following concepts are summarized from the provincial framework. For a more detailed discussion of any of these concepts, please see *Building capacity—A framework for serving Albertans affected by addiction and mental health issues.*[15]

Principles of service

Accepting, accessible and capacity-focused: Service is accepting of client needs and is welcoming, non-judgmental, hopeful, culturally sensitive, and respectful. Service is client-centered. People can come to an addiction service or mental health service and be helped. The service recognizes and builds on capacities: client, family and community strengths and informal and formal resources.

Least intrusive: The most appropriate service is that which is the least intrusive and ensures safety and effectiveness.

Comprehensive: There is a range of service available. Service includes universal screening for either addiction or mental health issues. Treatment planning is dynamic, holistic (integrates all relevant life areas) and establishes priorities and direction.

Evidence-based: Quality research, including program evaluation, guides policy and practice. Knowledge is effectively transferred from research to practice.

Sustainable: Resources are in place so that service providers can meet the need.

Characteristics of service delivery

Safety and stabilization: The safety of the client and others who may be at risk for harm takes precedence over all other decisions. Once safety is ensured, stabilization, if required, is the focus prior to further treatment.

Individuality and self-determination: Interventions are personalized and clients determine the level of intervention. Harm reduction approaches are used where appropriate.

Continuity: Clients experience a seamless approach to care. Addiction and mental health service sites develop protocols to ensure continuous care.

[15] This document can be downloaded from www.aadac.com

Consumer participation: Participation in mutual aid and advocacy groups is encouraged; support to the development or expansion of these groups is provided if possible.

Leadership: Leadership at the service and system level ensures progress. Leadership activities include articulating a vision that inspires, and leading the development, implementation and monitoring of services.

Appendix B

Models of case management

The following are brief descriptions of other models of case management. For a more detailed description and comparison of the models, see Table 1 that follows.

- Brokerage model: Other clinicians provide most services. The case manager acts as the intermediary for these services.
- Strengths model: This approach focuses on identifying client strengths and aspirations as opposed to focusing on illness, or deficits. Within an empowerment philosophy, treatment focuses on building new competencies, enhancing motivation, and improving social support.
- Rehabilitation model: This model is similar to the Strengths model. It has an emphasis on the improvement of skills and competencies that will prolong community stays (instead of accessing frequent emergency and/or residential long-term services) and helping clients achieve their goals.
- PACT/ACT/ICM models: These acronyms stand for:
  - PACT: Program for Assertive Community Treatment
  - ACT: Assertive Community Treatment
  - ICM: Intensive Case Management.

PACT was the original model for later ACT programs. These models all have an emphasis on high intensity of service. The original PACT/ACT models required the provision of clinical services by case managers. However, caseloads are shared, and services are provided by a team of clinicians rather than individually assigned. The clients get to know and can rely on, more than one clinician. Other characteristics are: 24-hour crisis intervention service, service provided in community settings such as clients homes, and indefinite service. The ACT model was developed to meet the needs of clients who were severely mentally ill and who were likely to have frequent rehospitalizations and relapses. This model also incorporates a multidisciplinary team that is responsible for providing service to clients. Cases are shared across the treatment team and smaller caseloads are used. These approaches have been shown consistently to be more effective when used for people who have severe and persistent mental illness.[35]

[35] Mehr, J. (2001). Case management: A review with implications for services for concurrent severe mental illness and alcoholism and substance abuse. *Psychiatric Rehabilitation Skills*. 5(1)92.

Table of case management models

Mehr[17] draws upon several reviews of the literature on case management for the following descriptions. Mueser, Noordsy, Drake, and Fox[18] also reviewed case management research. The following is a summation of their findings, presented primarily in the order that the models developed.

Table 1

Model	Description	How it evolved
Brokerage	· A generic model that has been used in many different human service fields · Case managers identify problems and develop plans and act as a broker of service and an intermediary between the service and the client[17]	· This is the original case management model · It has the longest history of all the models · Prior to 1978, the dominant model for community health agencies[17]
Strengths	· Focuses on client strengths and aspirations, as well as resources and opportunities in the community that can support efforts at wellness [18]	· Developed in response to concerns that case management and treatment in general overemphasized "deficits" and overlooked strengths[18]
Rehabilitation	· Much in common with the Strengths model · Focus on identifying the client's unique needs and goals · Greater emphasis on assessing skills deficits and working to build these skills up. (For example, teaching housekeeping skills)[17]	· Developed to take the focus off the perceived goals of the mental health system, such as reducing expensive hospital stays[17]
Program for Assertive Community Treatment (PACT)	· Emphasis on development of clinical relationships with client and family · Combines case management and clinical service. Clients receive individual help with symptom management, meeting basic needs and improvement of functioning in various areas (family, social, and others) · Crisis service · Multidisciplinary team provides service · Indefinite length of service · Multiple case managers · Service provided in the community[17] · First implemented in the 1970s.	· This was the original model for the Assertive Community Treatment (ACT) model outlined below. They are virtually the same.[17]

[17] Mehr, J. (2001). Case management: A review with implications for services for concurrent severe mental illness and alcoholism and substance abuse. *Psychiatric Rehabilitation Skills, 5*(1).

[18] Mueser, K., Noordsy, D., Drake, R. and Fox, L. (2003). *Integrated treatment for dual disorders: A guide to effective practice*. New York: Guilford Press.

Assertive Community Treatment (ACT)	· Service providers reach out to clients by providing services in clients natural living environments · Helpful in engaging clients and monitoring treatment · A multidisciplinary team provides service; caseloads are shared · 24-hour crisis intervention services available · This team carries smaller caseloads than usual due to the intensity and complexity of the issues and the outreach component	· The ACT model was first developed to meet the needs of a subgroup of clients with severe mental illness who were prone to rehospitalizations because they were unable or unwilling to access local mental health clinics · This model further illustrates the trend away from brokered services
Intensive (ICM)	· Emphasis on high intensity of service, described as Level I service by the National Association of Case Managers (USA)[37] · These programs depart from the PACT/ACT models in that they have higher ratios of client to team, and may or may not have a complete team of service providers · They may not meet the criteria for high frequency contacts, described by the PACT/ACT models, particularly in the rural areas · There may be individual case managers organized into teams · A significant feature is the availability of psychiatric and nursing services · Service provided in the community or client's home	· Based on the ACT/PACT models · Varying fidelity to the defining components of the ACT/PACT models
Clinical[38]	· Direct delivery of clinical services as well as brokerage and advocacy functions · Considers client strengths and community resources · Overall goals are to assess client needs, identify and provide/facilitate necessary services to meet those needs and to monitor outcomes · Most effective when services are provided by a multidisciplinary team · Outreach is a common component · With more clinical services provided directly, chances of not following through on referrals are minimized	· Incorporates aspects of the ACT model and the Strengths model · Blends the brokerage and advocacy functions of the Brokerage model with the provision of clinical services

Appendix C

Domains of care

A domain of care is a term used to describe a type and level of service. Considering a client's needs in terms of the appropriate domain of care, based on the nature of the concurrent disorder, is helpful in treatment planning. The provincial framework identifies the following domains of care:[39]

The first domain seeks to meet the needs of those whose issues are mild, and therefore do not enter formal treatment systems. Information, prevention and early intervention services are appropriate for this group. Services may be provided in "readily accessible settings including public health units, physicians' offices and other primary health-care locations, schools and locations where a high level of risk exists..."[40]

People with more severe problems are seen in the second and third domains of care. The second domain of care provides services for those with severe mental health problems and milder addiction problems. Mental health services will provide most of the treatment and follow up with this group of people and collaborate and consult with addictions professionals.

The third domain of care serves those with milder mental health problems and more severe addiction problems. They are more likely to be seen in addiction settings. Addictions treatment is the focus of the care and addictions professionals collaborate and consult with mental health clinicians.

The fourth domain serves those with severe addiction and mental health problems. Those with severe addiction and mental health problems will likely need access to a more intensive and specialized level of service, referred to as "concurrent disorder enhanced." Concurrent disorder enhanced services are fully integrated services for mental health- and substance-related issues. People who need this level of service are generally those that require more intensive care with a focus on stabilization, with attention to how the client's home environment will support the client's efforts at wellness when they are discharged.[41]

[39] AADAC. (2005). *Building capacity–A framework for serving Albertans affected by addiction and mental health issues*. Edmonton: Author.

[40] AADAC. (2005). *Building capacity–A framework for serving Albertans affected by addiction and mental health issues*. Edmonton: Author. (p. 22).

[41] AADAC. (2005). *Building capacity–A framework for serving Albertans affected by addiction and mental health issues*. Edmonton: Author.

Appendix D

Concurrent disorder capable service

Within the provincial framework for service to Albertans who have concurrent disorders, service providers are asked to adopt a shared responsibility for care. All services, whether they are primarily focused on addiction or mental health, should be concurrent disorder capable. (Some services will deliver a more intense level of service, that is, concurrent disorder enhanced service. See Appendix C for a description.)

In a concurrent disorder capable level of care, the focus of addictions workers is addiction-related issues but they are also capable of serving clients who have relatively stable co-occurring mental health problems. A guideline is that the mental health disorder is stable enough, and the person can function at an independent enough level that the mental health disorders do not interfere with the treatment of the addiction. Addictions workers also screen for mental health disorders and have sufficient training and experience to recognize the potential for the existence of mental health issues and refer to mental health services as appropriate.

For mental health services, concurrent disorder capability means that the service has as its primary focus the treatment of mental health problems but they are also capable of helping clients who have detoxified and have substance misuse problems. Mental health workers would be able to screen for addiction, and refer to an addiction service when appropriate.

The framework suggests that each part of the service system works with the other to help develop concurrent disorder capability: "Through consultation, collaboration and training, each component of the service system would be organized to help the other parts of the system develop its own capacity…"[42]

[42] AADAC. (2005) *Building capacity—A framework for serving Albertans affected by addiction and mental health issues.* Edmonton: Author. (pp. 18-19).

Appendix E

Potential challenges

The following list of potential challenges is adapted and summarized from *Case Management for Substance Abuse Treatment: A Guide for Treatment Providers.*[43]

It is important to remember that all involved are working in the best interests of the client and that open, frank, and frequent communication can help resolve disagreements.

Challenges may arise out of the following situations:

- unrealistic expectations about agencies, their services, and outcomes of the service
- final decision-making and other authority over the management of a case
- disenchantment after the "honeymoon" period fades
- differences in values, goals and definitions of the issues
- clients who pit one case manager against the other
- resentment over time involved in case management activities, especially that which takes professionals away from direct client care
- differences in professional credentials and corresponding perception of difference in professional status
- unclear problem resolution protocols for agency staff

Please see Appendix F for ideas about building solid service linkages and managing challenges.

[43] Substance Abuse and Mental Health Services Administration. (2000). *Case management for substance abuse treatment: A guide for treatment providers.* Rockville, MD: Author.

Appendix F

Working together

This information is adapted from *Building Strong Communities: Working in Partnership.*[44] It is intended to help service providers consider their relationship with each other and to improve how they work together to build effective case management practices, while recognizing that currently there are mutual understandings, including case management arrangements, that work well.

The following outline is not prescriptive and can be used in whatever way best benefits the service providers involved. For example, it could simply be used as a guide for discussion between service providers.

Know yourself

A first step is to "**know yourself**", that is, know your service:

- If there was a vision statement for your site's case management work, what would it say?
- What are your site's strengths in this area? What is working well?
- What are the first steps to take to move toward the vision? What do you need to know, or do right now? What initial steps can you take right now?
- How will this initiative affect your other business?
- Who at your site will champion this?
- Are there limits or challenges to your site's case management services? For example, information-exchanging agreements that need to be finalized or clarified? Are there legal requirements that need special attention?

Clarify expectations and provide information about the organization

- What does your organization need, want or expect from other service providers to build better case management practices?
- What can your organization offer? (skills/expertise, opportunities to showcase services, etc.)
- Provide information about your organization or service site (vision/mission/history of organization/site, long- and short-term objectives)

[44] Alberta Community Development. (2006). *Building strong communities: Working in partnership.* [Electronic version]. Retrieved January 21, 2006 from http://www.cd.gov.ab.ca/building_communities

Define the purpose of the service/align the mission

- Can you come up with a mission statement for the case management services that all partners will support?
- What is each committing to the service?
- Do the partners understand each other's purpose and the work each does?
- What are the mission, values and strategies of each participating organization?
- Are the cultures compatible? Are things done in the same way? If not, is each aware of the uniqueness and respect the other's differences?
- What is the social value created by the organizations working together?

Communication and quality of relationship

- What level of respect and trust exists right now?
- Is communication open and frank?
- Is there someone responsible for ongoing communication?

Make a plan to work together

Steps to take to make a plan:

- List the objective(s) of the case management services.
- Describe and define case management activities. What activities are expected from each participating organization?
- Determine what the information and communication needs are for each service provider.
- Identify the resources required and who is responsible for what.
- Set up a conflict resolution procedure.
- Determine how to monitor and evaluate the case management work.

Make it work

- Make sure the plan is realistic.
- Review communication commitments; ensure that the plan is communicated.
- Monitor the results.
- Look to the future—is their progress? Are objectives being met?

Managing challenges

Every relationship has issues or challenges. Whatever these issues and challenges are, address them in a timely manner. This is important for effective service delivery.

- Are there issues that service providers did not consider? For example, concerns about mandate or time commitments?
- Were there assumptions made about each other that have turned out to be untrue?
- Are there differences regarding the overall strategy or purpose of the service efforts?
- Were there details overlooked or misrepresented/misunderstood in the discussion between service providers?
- Are there differing interpretations of the progress being made? Are the vision and expectations of each service provider being met?

Appendix G

Sample scope of practice guidelines[45]

Practice guidelines for addiction counsellors working with clients who have co-occurring addiction and mental health issues.[46]

The following actions are based on a philosophy that endorses a co-ordinated and collaborative treatment approach.

1. Convey a welcoming and empathic attitude.
2. Screen for both addiction and mental health issues.
3. Check for mental health and detoxification issues that need immediate attention, for example, risk for suicide. Know how to get the person to safety.
4. Obtain an assessment of the other condition. If an assessment has not been completed, and is indicated by screening, arrange to have it happen.
5. Identify what stage of change the person is at for each issue. This may be different for different aspects of each issue. For example, a person may be precontemplative about abstinence from marijuana, but ready to work on abstinence from cocaine.
6. Understand the person's treatment plan and how it manages each issue. Collaborate and communicate with other providers so that the client receives a consistent message about treatment.
7. Provide individual and group interventions for education and motivational enhancement. Promote dual recovery meeting attendance when it is appropriate for the client.
8. Provide specific skills training to reduce substance use and/or manage mental health issues, as well as general skills training. Simplify skills training to accommodate a client's cognitive or emotional learning impairment or disability, regardless of cause. For example, teach the client how to set up a date to meet for lunch.
9. Enhance the motivation, and encourage, the client to follow the treatment plan, including prescribed medication. For example, educate clients about the appropriateness of taking psychiatric medications and participating in mental health treatment while attending mutual aid groups and participating in other addiction treatment.
10. Teach clients how to access and advocate for both mental health and addictions services and advocate for service provision as needed.

[45] Scope of practice refers to the range of and boundaries for professional activities. This example describes the scope of practice for addiction counsellors working with clients who have concurrent disorders.

[46] This information is an adaptation and summation of the article: "Integrated Scope of Practice for Singly Trained Clinicians Working with Clients with Co-occurring Disorders". Reference: Minkoff, K. (2003, October) *Counsellor: The magazine for addiction professionals, 4*(5), 24-27.

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